

[FE-10-98](#) (document link)

SUMMARY FOR FE-10-98:
SELECTED AND POSSIBLE CONTRIBUTING FACTORS

SELECTED FACTORS

Railroad: Long Island Railroad

Location: Queens, New York

Region: Region 1

Month: March

Date: 03/11/98

Time: 7:40 p.m., EST

Data for Fatally Injured Employee(s)

Machinist

30 years old

87 days of service

Last safety training: daily

Last physical: November 1997

Data for all Employees (Craft, Positions, Activity)

Craft: MOE

Positions:

Off-duty Machinist

Train No. 4715

Engineer

Conductor

Brakeman

Train No. 774

Conductor

Activity: **Heading home, the Machinist took the wrong train. He de-boarded the train and was walking back to Hollis Station.**

SUMMARY FOR FE-10-98 CONTINUED

POSSIBLE CONTRIBUTING FACTORS

EVENT

A Machinist was struck by a westbound train and fatally injured.

PCF No. 1

The incident occurred when the Machinist failed to remain clear of the mainline track.

PCF No. 2

Having completed his assigned shift plus five overtime hours, the Machinist was possibly fatigued and not alert to danger on the tracks.

PCF No. 3

The Machinist was inexperienced, having completed only 87 days of service. However, he had attended on-track safety training for mechanical department employees and had received daily safety training.

PCF No. 4

It was dark when the Machinist was walking along four heavily traveled, parallel mainline tracks. Also, his vision was obstructed by another westbound train slightly ahead on an adjacent track.

REPORT: FE-10-98

RAILROAD: Long Island Rail Road (LIRR)

LOCATION: Queens, New York

DATE, TIME: March 11, 1998 7:40 p.m., EST

PROBABLE CAUSE: Failure to remain clear of mainline track

EMPLOYEE: Occupation: Machinist

Age: 30 Years

Length of Service: 87 Days

Last Safety Training: Daily

Last Physical Examination: Nov. 18, 1997

CIRCUMSTANCES PRIOR TO THE ACCIDENT

On March 11, 1998, at approximately 7:40 p.m., an off-duty Long Island Railroad (LIRR) Machinist was fatally injured when he was struck by a westbound LIRR train. The accident occurred on Track No. 3 near milepost 11.6 of the railroad's mainline just west of Hollis Station in Queens, New York. At this location, the railroad comprised four heavily-used mainline tracks numbered from north to south: 3, 1, 2, and 4. The railroad was geographically oriented east and west, corresponding to timetable directions. The current of traffic on Tracks Nos. 3 and 1 was predominately westbound, and the current of traffic on Tracks Nos. 2 and 4 was predominately eastbound. The maximum authorized speed for passenger trains operating on Track No. 3 was 80 mph. The method of operation over this portion of the railroad is governed by the LIRR's Operating Rules and controlled by an automatic block signal system (ABS) and automatic speed control system (ASC).

On the day of the accident, the LIRR machinist reported for his 6 a.m. to 2 p.m. shift at the railroad's Hillside Maintenance Complex in Queens, NY. After completing his assigned shift, he continued working overtime until 7:20 p.m. (five hours). He then proceeded to Hillside Station (employee's platform) to catch a train home. He mistakenly boarded the wrong train (Train No. 774) home. After being informed by a crew member of this, he got off the train at the next scheduled stop. After getting off the train at Hollis Station, he crossed from the south side platform to the north side platform and began walking westward along the railroad right-of-way back to Hillside Station. The tracks in the area were tangent, and the grade was level. The time was approximately 7:40 p.m.

On the day of the accident, the 3-person crew (Engineer, Conductor and Brakeman) of LIRR Train No. 4715 reported for duty at Jamaica Station at 3:43 p.m. The crew was assigned to take a non-revenue train to West Side Yard at Penn Station, NY.

After arriving at Penn Station, the crew was assigned to operate express Train No. 1732 eastbound to Huntington, NY and return the same equipment to Penn Station as Train No. 4715. Train No. 4715, consisting of 12 (MU-1, electric) passenger cars departed Huntington Station westbound at 7:05 p.m., en route to Penn Station. The Engineer was seated at the controls in the control cab of the lead MU (9497). The Conductor was standing next to the Engineer's control cab door, facing forward. The train was operating on Track No. 3 and had just passed Hollis Station approaching the 190th Street bridge at 60 mph with the headlight on.

It was dark, and weather conditions were clear with light winds. The temperature was approximately 30° F.

THE ACCIDENT

The Engineer and Conductor both observed an individual running westward along the north side of Track No. 3. The Engineer activated the emergency brakes and sounded the horn. The Conductor noticed another train (symbol unknown) ahead of them on the adjacent track (Track No. 1), traveling in the same direction (west). The front of the other train had passed the individual's location when the Conductor first noticed him. The individual was struck by the right front of the lead MU (9497). The trailing unit of the train came to a halt approximately 200 feet west of the point of impact. The Conductor walked back to the point of impact and awaited the arrival of emergency response personnel. The individual was pronounced dead at the scene, and the remains were removed to the Queens mortuary at 10:30 p.m.

POST-ACCIDENT INVESTIGATION

Written witness statements of the Engineer and Conductor of Train No. 4715 were obtained by the LIRR Police Department. Interviews with the Conductor on Train No. 774 were conducted by the LIRR Police Department. The Engineer of Train No. 4715 took no exception to the condition of the equipment he was operating. The brakes, lights, and horn functioned as intended. The railroad's mechanical department personnel conducted post-accident inspections of the equipment and conducted tests of the train brakes. No exceptions were noted.

FRA reviewed LIRR's training records for employees and specifically the training received regarding on-track safety. The railroad's Safety Department conducted on-track safety training for mechanical department employees. Training records indicate that the employee had attended the training.

The Queens County Medical Examiner indicated the cause of death as "Severe Blunt Injury Trauma." The Medical Examiner's report indicated the manner of death as "accidental."

APPLICABLE RULES

LIRR Safety Rule No. 4060

“Walking on, or even being on railroad tracks, except in the direct line of duty, is prohibited. If duty makes it necessary to be on the tracks, a sharp lookout must be kept for trains approaching in either direction (at any time), even on double track. Movements may be made in either direction. Walk beside the track, clear of engines and cars, instead of on it. If it is necessary to cross railroad tracks, look in each direction, keeping a minimum of 10 feet from standing locomotives and cars. Do not pass between parts of a train or between cars standing close together without making certain that it is safe to do so.”